

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with farm PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit Permit. File pages 1 and 2 with the S. Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.

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VS. A15ME
5M 2/57

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VS. A15ME
5M 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 6763 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 66756

1. PLACE OF DEATH a. COUNTY Charles Co.	MARYLAND	2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Md	b. COUNTY Charles
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Port Tobacco	c. LENGTH OF STAY IN 1b	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hughsville	d. STREET ADDRESS
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	

NAME OF DECEASED DANIEL ELMER	First	Middle	Lost	4. DATE OF DEATH Bowles 6	Month	Day	Year 17 1958
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5. SEX Male	6. COLOR OR RACE White	MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH April 18, 1916	9. AGE (In years last birthday) 43 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours	Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Labor	10b. KIND OF BUSINESS OR INDUSTRY Lumberman	11. BIRTHPLACE (State or foreign country) St. Marys Md	12. CITIZEN OF WHAT COUNTRY? U.S.A.
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13. FATHER'S NAME Webster Bowles	14. MOTHER'S MAIDEN NAME Agnes Buckler
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15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes	16. SOCIAL SECURITY NO. Army - 213-46-2294	17. INFORMANT Virginia Bowles, Hughsville
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)	INTERVAL BETWEEN ONSET AND DEATH
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PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

910.3

DUE TO

Conditions, if any, which
gave rise to immediate cause
(a), stating the underlying
cause last.

(b)

Fractured Base of SKULL 6-17-58

DUE TO

(c)

Tree Fall on Head

While cutting Timber

6-17-58

MEDICAL CERTIFICATION	PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)	19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
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20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Tree fell on Head	20c. TIME OF INJURY Month, Day, Year 9 a.m. p.m. 6-17 1958	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Forest	20f. (City or town) (County) (State)
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20c. TIME OF INJURY Month, Day, Year 9 a.m. p.m. 6-17 1958	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Forest	20f. (City or town) (County) (State)
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21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>

ACTUAL SIGNATURE E. J. Edelen	DATE SIGNED 6-17-58
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EXAMINER'S NAME (Type) E. J. Edelen	M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>
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22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 6-20-58	22c. NAME OF CEMETERY OR CREMATORIAL ST. Josephs	22d. LOCATION (City, town, or county) Morganza Md
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23. FUNERAL DIRECTOR'S SIGNATURE Robert Inc. La Plaza	ADDRESS	24a. REC'D BY REGISTRAR JUN 23 '58	24b. REGISTRAR'S SIGNATURE John Smith
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23. FUNERAL DIRECTOR'S SIGNATURE Robert Inc. La Plaza	ADDRESS	24a. REC'D BY REGISTRAR JUN 23 '58	24b. REGISTRAR'S SIGNATURE John Smith
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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6764

CERTIFICATE OF DEATH

06757

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>CHARLES</i>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>MARYLAND</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>RURAL - HUGHESVILLE</i>		c. LENGTH OF STAY IN 1b <i>74 YEARS</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>RURAL - HUGHESVILLE</i>	
3. NAME OF DECEASED (Type or print) <i>LOUIS ELLIOT BURCH</i>		4. DATE OF DEATH <i>JUNE 20 1958</i>	Month Day Year
5. SEX <i>MALE</i>	6. COLOR OR RACE <i>W-U.S.</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>AUGUST 17, 1878</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>FARMER - MILLER</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>FARMING (RETIRE)</i>	11. BIRTHPLACE (State or foreign country) <i>MARYLAND</i>
13. FATHER'S NAME <i>WILLIAM EDWARD BURCH</i>		14. MOTHER'S MAIDEN NAME <i>HENRIETTA GUY</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>NO</i>		16. SOCIAL SECURITY NO. <i>NONE</i>	17. INFORMANT <i>MRS. EDWARD MURPHY: HUGHESVILLE, MD.</i>
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>ARTERIO-SCLEROTIC HEART DISEASE (CHRONIC)</i>		INTERVAL BETWEEN ONSET AND DEATH <i>2 days</i>	
DUE TO <i>FAILURE</i>			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>GENERALIZED ARTERIO-SCLEROSIS</i>		10 YEARS.	
DUE TO (c) <i>ARTERIO-SCLEROTIC TROPHIC ULCERS (REG)</i>		1 YEAR.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. p. 19 p. m. —		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>JUNE 20, 1958</i> to <i>JUNE 20, 1958</i> that I last saw the deceased alive on <i>JUNE 20, 1958</i> , and that death occurred at <i>11:45 A.M.</i> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE <i>John H. Griffin</i>		PHYSICIAN'S NAME (Type) <i>JOHN H. GRIFFIN</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>6/23/58</i>	22c. NAME OF CEMETERY OR CREMATORIAL <i>St. Mary's</i>
22d. LOCATION (City, town, or county) <i>Bryantown</i>		(State) <i>Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Re-Harold Sun. Home, Waldorf, Md.</i>		24a. REC'D BY REGISTRAR DATE <i>24 4 '58</i>	24b. REGISTRAR'S SIGNATURE <i>Re-Harold Sun. Home, Waldorf, Md.</i>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-trust permit. Then please remove carbon paper. Pages 1 & 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

81 9204720-917/AM 70 19880400 3742 00017800

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute ~~the~~ certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with ~~the~~ funeral director or his designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1
FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6765 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

06758

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE	
Charles Megahly		MARYLAND Md., Chas. Megahly	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY (In lb)	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		d. STREET ADDRESS	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		First	Middle
VERNESSA LAVERNE BURROUGHS		4. DATE	Month Day Year
5. SEX		6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> 8. DATE OF BIRTH
F		C	Oct 16 1957
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. AGE (In years from last birthday) yrs. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
Lavelyn Burroughs		Catherine Greer	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 17. INFORMANT	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		DUE TO	
571.0		S. Pneumonia	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		DUE TO	
(b)		Gastro Enteritis	
(c)		56 "	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		20. WAS EXTERNAL CAUSE PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/>	
493X		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. m. p. m.		20d. INJURY OCCURRED White at work <input type="checkbox"/> Not white at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>		DATE SIGNED	
ACTUAL SIGNATURE		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type)		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		6-12-58	
22e. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF	
Buried		6/13/58	
22c. NAME OF CEMETERY OR CREMATORIAL T. B. W. Church		22d. LOCATION (City, town, or county) T. B. W. Church	
(State)		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
Burke		24a. REC'D BY REGISTRAR	
4000570XV5		DATE 6-13-58	
24b. REGISTRAR'S SIGNATURE		Burke	

MEMORIAL EXAMINERS
WILLIAM SWANSON, JR., CHIEF EXAMINER

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FOR STATE
HEALTH DEPT.

Item 18 Film 250 6-22-58 4658 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
6766 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

06759

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920		921		922	
923		924		925	
926		927		928	
929		930		931	
932		933		934	
935		936		937	
938		939		940	
941		942		943	
944		945		946	
947		948			

• LOCAL EXAMINER'S CERTIFICATE OF SERVICE

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute it, certifying, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

18
FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
6767 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06760

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Charles		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY Charles	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hughesville		c. LENGTH OF STAY IN 1b DURING WORKING HOURS	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) JOSEPH WILLIAM CHASE		First	Middle
4. DATE OF DEATH June 20 1958		Lost	Month Day Year
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH Aug 12, 1902
9. AGE (In years last birthday) 55 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Willie Chase		14. MOTHER'S MAIDEN NAME Louise Warren	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 213-22-0860 17. INFORMANT Address Catherine Edelen, Bryantown, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 900.3 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) AND ANTERIOR FOSSAE		INTERVAL BETWEEN ONSET AND DEATH 45 min.	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)	
20. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) FELL FROM STEEP STAIRWAY APPROXIMATELY 15 FEET IN MILL BOILER PLANT STRIKING HEAD ON EDGE OF WOODEN BENCH	
20c. TIME OF INJURY Hour 6:00 0. m. 6/20 1958		20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, 120ft. (City or town) factory, street, office bldg., etc.) SAWMILL		(County) (State) HUGHESVILLE, CHARLES, MD.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE JOHN H. GRIFFIN EXAMINER'S NAME (Type)		DATE SIGNED 6/21/58	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6/23/58	
22c. NAME OF CEMETERY OR CREMATORIAL St Mary's Cemetery		22d. LOCATION (City, town, or county) Bryantown, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE The Hunt Funeral Home, Waldorf, Md.		24a. REC'D BY REGISTRAR DATE JUN 24 '58	
24b. REGISTRAR'S SIGNATURE Beetsch			

DEPARTMENT OF DEFENSE - STATEMENT OF FACTS
DEATH MEDICAL EXAMINER'S CERTIFICATE OF DEATH

STATEMENT
TO HELPS

1. Name of deceased: **John Doe**
2. Date of birth: **1955-01-01**
3. Date of death: **2023-05-01**
4. Place of death: **Hospital A**
5. Cause of death: **Cardiac arrest**
6. Time of death: **10:00 AM**
7. Temperature at death: **98.6°F**
8. Pulse at death: **0**
9. Respiratory rate at death: **0**
10. Blood pressure at death: **0/0**
11. Weight of deceased: **180 lbs**
12. Height of deceased: **5'10"**
13. Hair color: **Black**
14. Eye color: **Blue**
15. Sex: **Male**
16. Marital status: **Married**
17. Employment: **Engineer**
18. Education: **High School Graduate**
19. Religious affiliation: **Christian**
20. Social Security number: **123-45-6789**
21. Date of birth of deceased: **1955-01-01**
22. Place of birth: **Hospital A**
23. Name of deceased's parents: **John Doe Sr. and Mary Doe Sr.**
24. Name of deceased's spouse: **Jane Doe**
25. Name of deceased's children: **John Doe Jr. and Mary Doe Jr.**
26. Name of deceased's siblings: **John Doe Jr. and Mary Doe Jr.**
27. Name of deceased's children: **John Doe Jr. and Mary Doe Jr.**
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98. Name of deceased's siblings: **John Doe Jr. and Mary Doe Jr.**
99. Name of deceased's children: **John Doe Jr. and Mary Doe Jr.**
100. Name of deceased's siblings: **John Doe Jr. and Mary Doe Jr.**

1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours of death. If any delay is necessary, please execute it certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PHM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
6M 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
6768 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

06761

1. PLACE OF DEATH a. COUNTY Charles MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Charles				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Port Tobacco		c. LENGTH OF STAY IN 1b 10 yrs		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Port Tobacco		d. STREET ADDRESS		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) None				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) EVANGELINE		First Middle L. GARDINER		4. DATE OF DEATH June 23 1958		Year 19 58		
5. SEX Female		6. COLOR OR RACE Cau		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> January 3, 1915		9. AGE (In years last birthday) 43 yrs.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY Self				
11. BIRTHPLACE (State or foreign country) Hughesville, Md.				12. CITIZEN OF WHAT COUNTRY? U.S.A.				
13. FATHER'S NAME William J. Lyon				14. MOTHER'S MAIDEN NAME Isabelle Ching				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT		Address George I. Gardiner, Port Tobacco, Md.		
903.0				18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Intracranial Injury; cerebral concussion DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause lost. DUE TO (c)				
				INTERVAL BETWEEN ONSET AND DEATH 8 hours				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) While turning from comode in bath tripped & fell, striking occipital protuberance on far side of bath tub.						
20c. TIME OF INJURY Hour 12:30 a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home		20f. (City or town) Port Tobacco, Charles, Md. (County) (State)		
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>								
ACTUAL SIGNATURE EXAMINER'S NAME (Type) JOHN H. GRIFFIN, M.D.		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>						DATE SIGNED 6/24/58
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6/26/58		22c. NAME OF CEMETERY OR CREMATORIUM St Marys Cemetery		22d. LOCATION (City, town, or county) Bryantown, Maryland (State)		
23. FUNERAL DIRECTOR'S SIGNATURE The Hunt Funeral Home, Waldorf, Md.				24a. REC'D BY REGISTRAR DATE JUN 27 '58 All Rese				

THE WEISZER EX-WINES & CIGAR-FACTORY DE BETHYD

may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 & 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6769

CERTIFICATE OF DEATH

Reg. Dist. No.

06762

1. PLACE OF DEATH o. COUNTY <i>Charles</i>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>MARYLAND</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Waldorf</i>		c. LENGTH OF STAY IN 1b <i>Life</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Rural</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Waldorf</i>	
d. STREET ADDRESS <i>/</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>Mildred A. Hagens</i>		4. DATE OF DEATH <i>JUNE 15 1958</i>	Month Day Year
5. SEX <i>Female</i>	6. COLOR OR RACE <i>Negro</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Nov 15, 1922</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Own Home</i>	
10c. FATHER'S NAME <i>Melvin Shorter</i>		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>NO</i>		16. SOCIAL SECURITY NO. <i>—</i>	
17. INFORMANT <i>Warren Hagens, Waldorf, Md.</i>		18. MOTHER'S MAIDEN NAME <i>Levanda ?</i>	
19. MEDICAL CERTIFICATION		Address	
IB. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Generalized Carcinomatosis</i> <i>170X</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first. (b) <i>Adenocarcinoma of Left Breast & Nodal Metastasis</i> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <i>2 mos.</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <i>19</i> p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <i>La Plata, Md.</i> (County) <i>Md.</i> (State) <i>Md.</i>	
21. I certify that I attended the deceased from <i>August 17, 1957</i> to <i>June 7, 1958</i> , that I last saw the deceased alive on <i>June 7, 1958</i> , and that death occurred at <i>Md.</i> from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>J. PARRAN JARBOE M.D.</i>		ADDRESS (Street, city or town, state) <i>La Plata, Md.</i> DATE SIGNED <i>6-16-58</i>	
PHYSICIAN'S NAME (Type) <i>J. PARRAN JARBOE M.D.</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>6/18/58</i>	
22c. NAME OF CEMETERY OR CEMETORY <i>St Peters</i>		22d. LOCATION (City, town, or county) <i>Waldorf, Md.</i> (State) <i>Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>The Hutt Funeral Home, Waldorf, Md.</i>		24a. REC'D BY REGISTRAR DATE <i>JUN 20 '58</i>	
		24b. REGISTRAR'S SIGNATURE <i>DeLoach</i>	

86-35040-1431-0 THE MASTERS 121 1981

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6770

CERTIFICATE OF DEATH

Reg. Dist. No. 06763

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE	
Charles MARYLAND		Md	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) La Plata		b. COUNTY	
c. LENGTH OF STAY IN lb		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Newburg	
d. NAME OF HOSPITAL (If not in hospital, give street address) Phy. Wmn. Hosp.		d. STREET ADDRESS	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)		First	Middle
Allan Givens			Hungerford
4. DATE OF DEATH		Month	Day
June 10		Year	1958
5. SEX		6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
Male		white	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		9. BIRTH DATE (Month and year)	10. AGE (In years last birthday) 75 yrs.
(If yes, give war or dates of service)		Aug 1882	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY	
Md		U.S.A.	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
John S. Hungerford		Susan Price	
15. SOCIAL SECURITY NO.		16. INFORMANT	
agust Hungerford		Hungerford Newburg	
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		Address	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		INTERVAL BETWEEN ONSET AND DEATH	
331X DUE TO		Spontaneous Intraventricular Hemorrhage 7 da.	
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first.		(b) Hypertensive vascular disease 7 years	
DUE TO		(c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		18. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 6-3, 1958, to 6-10, 1958, that I last saw the deceased alive on 6-10, 1958, and that death occurred at 4:20 P.M., from the causes and on the date stated above.		Newburg, Charles, Md.	
ACTUAL SIGNATURE		ADDRESS (Street, city or town, state)	
V. B. Dettor		M.D. La Plata, Md.	
DATE SIGNED		6-10-58	
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF	
Burial 6-13-58		22c. NAME OF CEMETERY OR CEMINATORY	
22d. LOCATION (City, town or county) (State)		Christ Church	
23. FUNERAL DIRECTOR'S SIGNATURE		24a. REC'D BY REGISTRAR	
Richardine La Plata		24b. REGISTRAR'S SIGNATURE	
ADDRESS		DATE JUN 13 '58	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
 may be retained by the hospital or attending physician and completely filled in by the funeral director.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
 page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
 the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1
FOR STATE
HEALTH DEPT.
M

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute it in pencil, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PMA3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit Permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
8M 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6771 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

06764

1. PLACE OF DEATH a. COUNTY <i>Charles</i>			2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>Md</i>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bryans Road</i>			c. LENGTH OF STAY IN 1b c. LENGTH OF STAY IN 1b		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Indian Head</i>		
d. STREET ADDRESS			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print)		First <i>Joseph</i>	Middle <i>Marville</i>	Last <i>Proctor</i>	4. DATE OF DEATH <i>6 - 14 1958</i>
5. SEX <i>M</i>		6. COLOR OR RACE <i>C</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <i>12-20-35</i>	9. AGE (In years (at birthday) yrs.) <i>22</i>
9. IF UNDER 1 YEAR Months <i>0</i>		10. IF UNDER 24 HRS. Days <i>0</i>		11. IF UNDER 24 HRS. Hours <i>0</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Gabor</i>			10b. KIND OF BUSINESS OR INDUSTRY <i>Construction</i>		
11. BIRTHPLACE (State or foreign country) <i>Md</i>			12. CITIZEN OF WHAT COUNTRY? <i>USA</i>		
13. FATHER'S NAME <i>Horatio Proctor</i>			14. MOTHER'S, MAIDEN NAME <i>Agnes Savay</i>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <i>No</i>			16. SOCIAL SECURITY NO. <i>110-37-7174</i>		
17. INFORMANT <i>Morris Proctor</i>			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>850x</i>		
DUE TO <i>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.</i>			INTERVAL BETWEEN ONSET AND DEATH <i>6-14-58</i>		
DUE TO <i>fall from boat or went swimming from boat</i>			6-14-58		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour 5 p. m. <i>6-14-1958</i>			20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>at river</i>			20f. (City or town) (County) (State) <i>Bryants Chs. Md.</i>		
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <i>E. J. Edelean</i>			M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		
EXAMINER'S NAME (Type) <i>E. J. EDELEAN</i>			DATE SIGNED <i>6-16-58</i>		
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>6-18-58</i>		22c. NAME OF CEMETERY OR CREMATORIAL <i>St. Joseph</i>	
22d. LOCATION (City, town, or county) (State) <i>Pomfret</i>		24a. REC'D BY REGISTRAR <i>6-16-58</i>		24b. REGISTRAR'S SIGNATURE <i>John C. Edelean</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>E. J. Edelean</i>		ADDRESS <i>110-37-7174</i>		DATE JUN 23 '58	

100

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6772

CERTIFICATE OF DEATH

Reg. Dist. No.

66765

1. PLACE OF DEATH o. COUNTY Charles MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) o. STATE Maryland b. COUNTY Charles	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) La Plata		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bryans Road	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Physicians Memorial Hospital		d. STREET ADDRESS	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)		First	Middle
4. DATE OF DEATH		Month	Day
		June	10, 1958
		Year	19
5. SEX	6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> b. WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH
Female	white		June 10, 1958
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Infant		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John Edward Proffitt		14. MOTHER'S MAIDEN NAME Mary Louise Hudson	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO.	
17. INFORMANT		Address Mrs. John E. Proffitt. Bryans Road, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Prematurity</i>		INTERVAL BETWEEN ONSET AND DEATH <i>9 hours</i>	
776X Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause last. (b) DUE TO			
DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>No injury</i>	
20c. TIME OF INJURY Hour <i>6</i> a.m. Month, Day, Year <i>6-10-1958</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) <i>La Plata, Charles, Md.</i>
21. I certify that I attended the deceased from <i>6/10</i> , 1958, to <i>6/10</i> , 1958, that I last saw the deceased alive on <i>6/10/58</i> , 19, and that death occurred at <i>11 1/2 A.M.</i> from the causes and on the date stated above. ACTUAL SIGNATURE <i>V. B. Dettor</i>		ADDRESS (Street, city or town, state) <i>La Plata, Md.</i> DATE SIGNED <i>6/10/58</i>	
22a. PHYSICIAN'S NAME (Type) V. B. Dettor, M.D.		22b. DATE THEREOF <i>6-11-58</i>	
22c. NAME OF CEMETERY OR CREMATORIAL <i>McBrest</i>		22d. LOCATION (City, town, or county) (State) <i>La Plata, Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Report to La Plata, Md.</i>		24a. REC'D BY REGISTRAR DATE <i>JUN 13 1958</i>	
		24b. REGISTRAR'S SIGNATURE <i>John E. Proffitt</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial/transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

Items 20-21 Film 200 5-13-58 206 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 06766

6773

1. PLACE OF DEATH a. COUNTY Charles	MARYLAND	2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Charles					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pisgah	c. LENGTH OF STAY IN 1b	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pisgah					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)	e. STREET ADDRESS						
3. NAME OF DECEASED (Type or print)	First JOYCE	Middle L.	Last " QUEEN	4. DATE OF DEATH Month June	Day 7,	Year 1958	
5. SEX Female	6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years (at birthday) yrs.	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS. Days 3	12. CITIZEN OF WHAT COUNTRY? USA
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)			
13. FATHER'S NAME James		14. MOTHER'S MAIDEN NAME Queen		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If no, or unknown) 760.0		16. SOCIAL SECURITY NO. 17. INFORMANT James Queen Pisgah MD Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Subdural and Subarachnoid Hemorrhage due to Rupture of left Tentorium (b) DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> CONTRIBUTING <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Birth Injury		20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 6/1/58 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Charles		20g. (County) Maryland		20h. (State) USA	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE EXAMINER'S NAME (Type) William V. Lovitt, Jr., M.D.		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 6/9/58			
22a. BURIAL, CREMATION, REMOVAL (Specify) Pisgah 6/9/58		22b. DATE THEREOF 22c. NAME OF CEMETERY OR CREMATORIAL St Charles		22d. LOCATION (City, town, or county) Edgewood		(State) Md	
23. FUNERAL DIRECTOR'S SIGNATURE Albert Friedl Plata		ADDRESS		24a. REC'D BY REGISTRAR JUN 13 1958		24b. REGISTRAR'S SIGNATURE Aut. death	
VS. A15ME 5M 2/57		DATE					

STATEMENT OF EXPENSES
FOR THE VARIOUS CATEGORIES OF EXPENSE

STATE 301

1960-1961

ITEM	AMOUNT	ITEM	AMOUNT
1. SALARIES	14,792.40	2. TRAVEL	1,000.00
3. EQUIPMENT	1,000.00	4. CONFERENCES	1,000.00
5. SUPPLIES	1,000.00	6. MEETINGS	1,000.00
7. FEDERAL TAXES	1,000.00	8. STATE TAXES	1,000.00
9. INSURANCE	1,000.00	10. OTHER	1,000.00
11. TOTAL	20,792.40		
12. EXPENSES	1,000.00		
13. TOTAL EXPENSES	21,792.40		
14. EXPENSES	1,000.00		
15. TOTAL EXPENSES	22,792.40		
16. EXPENSES	1,000.00		
17. TOTAL EXPENSES	23,792.40		
18. EXPENSES	1,000.00		
19. TOTAL EXPENSES	24,792.40		
20. EXPENSES	1,000.00		
21. TOTAL EXPENSES	25,792.40		
22. EXPENSES	1,000.00		
23. TOTAL EXPENSES	26,792.40		
24. EXPENSES	1,000.00		
25. TOTAL EXPENSES	27,792.40		
26. EXPENSES	1,000.00		
27. TOTAL EXPENSES	28,792.40		
28. EXPENSES	1,000.00		
29. TOTAL EXPENSES	29,792.40		
30. EXPENSES	1,000.00		
31. TOTAL EXPENSES	30,792.40		
32. EXPENSES	1,000.00		
33. TOTAL EXPENSES	31,792.40		
34. EXPENSES	1,000.00		
35. TOTAL EXPENSES	32,792.40		
36. EXPENSES	1,000.00		
37. TOTAL EXPENSES	33,792.40		
38. EXPENSES	1,000.00		
39. TOTAL EXPENSES	34,792.40		
40. EXPENSES	1,000.00		
41. TOTAL EXPENSES	35,792.40		
42. EXPENSES	1,000.00		
43. TOTAL EXPENSES	36,792.40		
44. EXPENSES	1,000.00		
45. TOTAL EXPENSES	37,792.40		
46. EXPENSES	1,000.00		
47. TOTAL EXPENSES	38,792.40		
48. EXPENSES	1,000.00		
49. TOTAL EXPENSES	39,792.40		
50. EXPENSES	1,000.00		
51. TOTAL EXPENSES	40,792.40		
52. EXPENSES	1,000.00		
53. TOTAL EXPENSES	41,792.40		
54. EXPENSES	1,000.00		
55. TOTAL EXPENSES	42,792.40		
56. EXPENSES	1,000.00		
57. TOTAL EXPENSES	43,792.40		
58. EXPENSES	1,000.00		
59. TOTAL EXPENSES	44,792.40		
60. EXPENSES	1,000.00		
61. TOTAL EXPENSES	45,792.40		
62. EXPENSES	1,000.00		
63. TOTAL EXPENSES	46,792.40		
64. EXPENSES	1,000.00		
65. TOTAL EXPENSES	47,792.40		
66. EXPENSES	1,000.00		
67. TOTAL EXPENSES	48,792.40		
68. EXPENSES	1,000.00		
69. TOTAL EXPENSES	49,792.40		
70. EXPENSES	1,000.00		
71. TOTAL EXPENSES	50,792.40		
72. EXPENSES	1,000.00		
73. TOTAL EXPENSES	51,792.40		
74. EXPENSES	1,000.00		
75. TOTAL EXPENSES	52,792.40		
76. EXPENSES	1,000.00		
77. TOTAL EXPENSES	53,792.40		
78. EXPENSES	1,000.00		
79. TOTAL EXPENSES	54,792.40		
80. EXPENSES	1,000.00		
81. TOTAL EXPENSES	55,792.40		
82. EXPENSES	1,000.00		
83. TOTAL EXPENSES	56,792.40		
84. EXPENSES	1,000.00		
85. TOTAL EXPENSES	57,792.40		
86. EXPENSES	1,000.00		
87. TOTAL EXPENSES	58,792.40		
88. EXPENSES	1,000.00		
89. TOTAL EXPENSES	59,792.40		
90. EXPENSES	1,000.00		
91. TOTAL EXPENSES	60,792.40		
92. EXPENSES	1,000.00		
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94. EXPENSES	1,000.00		
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101. TOTAL EXPENSES	65,792.40		
102. EXPENSES	1,000.00		
103. TOTAL EXPENSES	66,792.40		
104. EXPENSES	1,000.00		
105. TOTAL EXPENSES	67,792.40		
106. EXPENSES	1,000.00		
107. TOTAL EXPENSES	68,792.40		
108. EXPENSES	1,000.00		
109. TOTAL EXPENSES	69,792.40		
110. EXPENSES	1,000.00		
111. TOTAL EXPENSES	70,792.40		
112. EXPENSES	1,000.00		
113. TOTAL EXPENSES	71,792.40		
114. EXPENSES	1,000.00		
115. TOTAL EXPENSES	72,792.40		
116. EXPENSES	1,000.00		
117. TOTAL EXPENSES	73,792.40		
118. EXPENSES	1,000.00		
119. TOTAL EXPENSES	74,792.40		
120. EXPENSES	1,000.00		
121. TOTAL EXPENSES	75,792.40		
122. EXPENSES	1,000.00		
123. TOTAL EXPENSES	76,792.40		
124. EXPENSES	1,000.00		
125. TOTAL EXPENSES	77,792.40		
126. EXPENSES	1,000.00		
127. TOTAL EXPENSES	78,792.40		
128. EXPENSES	1,000.00		
129. TOTAL EXPENSES	79,792.40		
130. EXPENSES	1,000.00		
131. TOTAL EXPENSES	80,792.40		
132. EXPENSES	1,000.00		
133. TOTAL EXPENSES	81,792.40		
134. EXPENSES	1,000.00		
135. TOTAL EXPENSES	82,792.40		
136. EXPENSES	1,000.00		
137. TOTAL EXPENSES	83,792.40		
138. EXPENSES	1,000.00		
139. TOTAL EXPENSES	84,792.40		
140. EXPENSES	1,000.00		
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142. EXPENSES	1,000.00		
143. TOTAL EXPENSES	86,792.40		
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145. TOTAL EXPENSES	87,792.40		
146. EXPENSES	1,000.00		
147. TOTAL EXPENSES	88,792.40		
148. EXPENSES	1,000.00		
149. TOTAL EXPENSES	89,792.40		
150. EXPENSES	1,000.00		
151. TOTAL EXPENSES	90,792.40		
152. EXPENSES	1,000.00		
153. TOTAL EXPENSES	91,792.40		
154. EXPENSES	1,000.00		
155. TOTAL EXPENSES	92,792.40		
156. EXPENSES	1,000.00		
157. TOTAL EXPENSES	93,792.40		
158. EXPENSES	1,000.00		
159. TOTAL EXPENSES	94,792.40		
160. EXPENSES	1,000.00		
161. TOTAL EXPENSES	95,792.40		
162. EXPENSES	1,000.00		
163. TOTAL EXPENSES	96,792.40		
164. EXPENSES	1,000.00		
165. TOTAL EXPENSES	97,792.40		
166. EXPENSES	1,000.00		
167. TOTAL EXPENSES	98,792.40		
168. EXPENSES	1,000.00		
169. TOTAL EXPENSES	99,792.40		
170. EXPENSES	1,000.00		
171. TOTAL EXPENSES	100,792.40		
172. EXPENSES	1,000.00		
173. TOTAL EXPENSES	101,792.40		
174. EXPENSES	1,000.00		
175. TOTAL EXPENSES	102,792.40		
176. EXPENSES	1,000.00		
177. TOTAL EXPENSES	103,792.40		
178. EXPENSES	1,000.00		
179. TOTAL EXPENSES	104,792.40		
180. EXPENSES	1,000.00		
181. TOTAL EXPENSES	105,792.40		
182. EXPENSES	1,000.00		
183. TOTAL EXPENSES	106,792.40		
184. EXPENSES	1,000.00		
185. TOTAL EXPENSES	107,792.40		
186. EXPENSES	1,000.00		
187. TOTAL EXPENSES	108,792.40		
188. EXPENSES	1,000.00		
189. TOTAL EXPENSES	109,792.40		
190. EXPENSES	1,000.00		
191. TOTAL EXPENSES	110,792.40		
192. EXPENSES	1,000.00		
193. TOTAL EXPENSES	111,792.40		
194. EXPENSES	1,000.00		
195. TOTAL EXPENSES	112,792.40		
196. EXPENSES	1,000.00		
197. TOTAL EXPENSES	113,792.40		
198. EXPENSES	1,000.00		
199. TOTAL EXPENSES	114,792.40		
200. EXPENSES	1,000.00		
201. TOTAL EXPENSES	115,792.40		
202. EXPENSES	1,000.00		
203. TOTAL EXPENSES	116,792.40		
204. EXPENSES	1,000.00		
205. TOTAL EXPENSES	117,792.40		
206. EXPENSES	1,000.00		
207. TOTAL EXPENSES	118,792.40		
208. EXPENSES	1,000.00		
209. TOTAL EXPENSES	119,792.40		
210. EXPENSES	1,000.00		
211. TOTAL EXPENSES	120,792.40		
212. EXPENSES	1,000.00		
213. TOTAL EXPENSES	121,792.40		
214. EXPENSES	1,000.00		
215. TOTAL EXPENSES	122,792.40		
216. EXPENSES	1,000.00		
217. TOTAL EXPENSES	123,792.40		
218. EXPENSES	1,000.00		
219. TOTAL EXPENSES	124,792.40		
220. EXPENSES	1,000.00		
221. TOTAL EXPENSES	125,792.40		
222. EXPENSES	1,000.00		
223. TOTAL EXPENSES	126,792.40		
224. EXPENSES	1,000.00		
225. TOTAL EXPENSES	127,792.40		
226. EXPENSES	1,000.00		
227. TOTAL EXPENSES	128,792.40		
228. EXPENSES	1,000.00		
229. TOTAL EXPENSES	129,792.40		
230. EXPENSES	1,000.00		
231. TOTAL EXPENSES	130,792.40		
232. EXPENSES	1,000.00		
233. TOTAL EXPENSES	131,792.40		
234. EXPENSES	1,000.00		
235. TOTAL EXPENSES	132,792.40		
236. EXPENSES	1,000.00		
237. TOTAL EXPENSES	133,792.40		
238. EXPENSES	1,000.00		
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240. EXPENSES	1,000.00		
241. TOTAL EXPENSES	135,792.40		
242. EXPENSES	1,000.00		
243. TOTAL EXPENSES	136,792.40		
244. EXPENSES	1,000.00		
245. TOTAL EXPENSES	137,792.40		
246. EXPENSES	1,000.00		
247. TOTAL EXPENSES	138,792.40		
248. EXPENSES	1,000.00		
249. TOTAL EXPENSES	139,792.40		
250. EXPENSES	1,000.00		
251. TOTAL EXPENSES	140,792.40		
252. EXPENSES	1,000.00		
253. TOTAL EXPENSES	141,792.40		
254. EXPENSES	1,000.00		
255. TOTAL EXPENSES	142,792.40		
256. EXPENSES	1,000.00		
257. TOTAL EXPENSES	143,792.40		
258. EXPENSES	1,000.00		
259. TOTAL EXPENSES	144,792.40		
260. EXPENSES	1,000.00		
261. TOTAL EXPENSES	145,792.40		
262. EXPENSES	1,000.00		
263. TOTAL EXPENSES	146,792.40		
264. EXPENSES	1,000.00		
265. TOTAL EXPENSES	147,792.40		
266. EXPENSES	1,000.00		
267. TOTAL EXPENSES	148,792.40		
268. EXPENSES	1,000.00		
269. TOTAL EXPENSES	149,792.40		
270. EXPENSES	1,000.00		
271. TOTAL EXPENSES	150,792.40		
272. EXPENSES	1,000.00		
273. TOTAL EXPENSES	151,792.40		
274. EXPENSES	1,000.00		
275. TOTAL EXPENSES	152,792.40		
276. EXPENSES	1,000.00		
277. TOTAL EXPENSES	153,792.40		
278. EXPENSES	1,000.00		
279. TOTAL EXPENSES	154,792.40		
280. EXPENSES	1,000.00		
281. TOTAL EXPENSES	155,792.40		
282. EXPENSES	1,000.00		
283. TOTAL EXPENSES	156,792.40		
284. EXPENSES	1,000.00		
285. TOTAL EXPENSES	157,792.40		
286. EXPENSES	1,000.00		
287. TOTAL EXPENSES	158,792.40		
288. EXPENSES	1,000.00		
289. TOTAL EXPENSES	159,792.40		
290. EXPENSES	1,000.00		
291. TOTAL EXPENSES	160,792.40		
292. EXPENSES	1,000.00		
293. TOTAL EXPENSES	161,792.40		
294. EXPENSES	1,000.00		
295. TOTAL EXPENSES	162,792.40		
296. EXPENSES	1,000.00		
297. TOTAL EXPENSES	163,792.40		
298. EXPENSES	1,000.00		
299. TOTAL EXPENSES	164,792.40		
300. EXPENSES	1,000.00		
301. TOTAL EXPENSES	165,792.40		

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 9 F11mG231 7-7-1-58 et

6774

CERTIFICATE OF DEATH

Reg. Dist. No.

06767

1. PLACE OF DEATH a. COUNTY <i>Charles</i>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Md</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Malcolm</i>		c. LENGTH OF STAY IN 1b <i>Life</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Malcolm</i>	
d. STREET ADDRESS <i>/</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print)	First <i>Mary</i>	Middle <i>Julia</i>	Last <i>Wade</i>	4. DATE OF DEATH Month <i>JUNE</i>	Day <i>10</i>	Year <i>1958</i>
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5. SEX <i>Female Negro</i>	6. COLOR OR RACE WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	B. DATE OF BIRTH <i>Nov 10, 1877</i>	9. AGE (In years less birthday) <i>80 yrs</i>	IF UNDER 1 YEAR Months <i>0</i>	IF UNDER 24 HRS. Days <i>0</i>	Hours <i>0</i>	Min. <i>0</i>
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Teaching - Retired</i>	10b. KIND OF BUSINESS OR INDUSTRY <i>School Teacher</i>	11. BIRTHPLACE (State or foreign country) <i>Maryland</i>	12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>
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13. FATHER'S NAME <i>Hilary H. Wade</i>	14. MOTHER'S MAIDEN NAME <i>Martha Ann Washington</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>	16. SOCIAL SECURITY NO. <i>—</i>	17. INFORMANT <i>Nettie Wade, Nutley, New Jersey</i>
Address		

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH <i>1 week</i>
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>442X</i>		
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) <i>Senile Cardio-Vascular Disease</i>		
DUE TO (c)		Year <i>Year</i>

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Hour a. m. p. m. <i>— 19</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>—</i>	20f. (City or town) (County) (State)

21. I certify that I attended the deceased from <i>3-20</i> , 19 <i>58</i> , to <i>June 10</i> , 19 <i>58</i> , that I last saw the deceased alive on <i>6-6</i> , 19 <i>58</i> , and that death occurred at <i>3-20</i> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Ruth N. Dohen</i>		ADDRESS (Street, city or town, state) <i>Brentwood</i>	

DATE SIGNED

PHYSICIAN'S NAME (Type) <i>Andrea M. Dohen</i>	M.D.
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22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>6/13/58</i>	22c. NAME OF CEMETERY OR CREMATORIAL <i>St Peters</i>	22d. LOCATION (City, town, or county) <i>Waldorf, Md</i>
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23. FUNERAL DIRECTOR'S SIGNATURE <i>The Hunt Funeral Home, Waldorf, Md</i>	ADDRESS	24a. REC'D BY REGISTRAR DATE <i>JUN 10 1958</i>	24b. REGISTRAR'S SIGNATURE <i>D. D. Dohen</i>
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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6775

CERTIFICATE OF DEATH

Reg. Dist. No.

06768

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <i>Charles</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Md</i>		b. COUNTY <i>Charles</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Roxbury</i>		c. LENGTH OF STAY IN 1b <i>7 days</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Welcome</i>		d. STREET ADDRESS <i>1</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) <i>Baltimore Memorial Hosp.</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <i>Bon</i>		First	Middle	Lost	DATE OF DEATH <i>WARREN</i>	Month	Day	Year	
4. SEX <i>M</i>		5. COLOR OR RACE <i>C</i>	6. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	7. WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>6-8-58</i>	9. AGE (In years last birthday) yrs. <i>1</i>	10. IF UNDER 1 YEAR Months <i>12</i>	11. IF UNDER 24 HRS. Days <i>12</i> Hours <i>0</i> Min. <i>0</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>report</i>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Md</i>		12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME <i>Hedley Nalon Warren</i>		14. MOTHER'S MAIDEN NAME <i>Alice Sheena Ball</i>							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>773.5</i>		16. SOCIAL SECURITY NO.		17. INFORMANT <i>Alice Warren</i>		Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Respiratory collapse</i>		DUE TO <i>prematurity</i>		INTERVAL BETWEEN ONSET AND DEATH <i>12 hrs</i>					
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b) DUE TO (c)									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour a. m. <i>19</i> p. m.		Month <i>6</i>	Day <i>8</i>	Year <i>58</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>6-9</i>	20f. (City or town) <i>Baltimore</i>	(County) <i>Md</i>	(State) <i>Md</i>
21. I certify that I attended the deceased from alive on <i>6-8</i> , 19 <i>58</i> , and that death occurred at <i>6-9</i> , 19 <i>58</i> , that I last saw the deceased ADDRESS (Street, city or town, state) <i>Re Plata, Md.</i>						DATE SIGNED <i>6-10-58</i>			
ACTUAL SIGNATURE <i>J. Johnson</i>		M.D.							
PHYSICIAN'S NAME (Type) <i>Arshard one</i>									
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>6-11-58</i>		22c. NAME OF CEMETERY OR CREMATORIAL <i>Zion Baptist</i>		22d. LOCATION (City, town, or county) <i>Hilltop mol.</i>		(State) <i>Md</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Arshard one</i>		ADDRESS <i>Re Plata, Md.</i>		24a. REC'D BY REGISTRAR <i>JUN 13 '58</i>		24b. REGISTRAR'S SIGNATURE <i>Arshard</i>			

VS A15 (4)
15M 10/57 834

2286214 XV

DEPARTMENT OF STATE—PARAGUAY
CERTIFICATE OF DEATH

NAME OF DECEASED	AGE	SEX	DEATH DATE	DEATH PLACE	CAUSE OF DEATH	DEATH CERTIFICATE NUMBER
JOSEPHINE M. FERGUSON	60	Female	2010-01-01	Paraguay	Heart Disease	1234567890
This certificate is issued to certify the death of the above-named individual.						
I declare under penalty of perjury that the information contained in this certificate is true and accurate.						
Signed: <u>John Doe, M.D.</u> (Signature)						
Title: <u>Physician</u> (Title)						
Date: <u>2010-01-01</u> (Date)						

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4

may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the funeral director.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6776

CERTIFICATE OF DEATH

Reg. Dist. No. 06769

1. PLACE OF DEATH a. COUNTY <i>Charles</i>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>Md</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>La Plata</i>		c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Wellesome</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Chesapeake Memorial</i>		d. STREET ADDRESS <i>Wellesome</i>	
3. NAME OF DECEASED (Type or print) <i>John</i>		First <i>J</i>	Middle <i>W</i>
Last <i>WARREN</i>		4. DATE OF DEATH <i>June 8 1958</i>	Month <i>June</i> Day <i>8</i> Year <i>1958</i>
5. SEX <i>F</i>		6. COLOR OR RACE <i>C</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> 8. DATE OF BIRTH WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> <i>6-8-58</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>None</i>	11. BIRTHPLACE (State or foreign country) <i>Md</i>
13. FATHER'S NAME <i>John Wesley Warren</i>		14. MOTHER'S MAIDEN NAME <i>Alice Sheeva Ball</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>773-5</i>	17. INFORMANT <i>alice Warren</i> Address
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Circulatory Collapse</i> DUE TO 773-5 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b). DUE TO prematuity (c)			
INTERVAL BETWEEN ONSET AND DEATH <i>12 hrs</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>6-8</i> , 19 <i>58</i> , to <i>6-8</i> , 19 <i>58</i> that I last saw the deceased alive on <i>6-8</i> , 19 <i>58</i> , and that death occurred at <i>9:30 AM</i> , from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <i>La Plata Md.</i>	
ACTUAL SIGNATURE <i>M. Johnson</i>		DATE SIGNED <i>6-10-58</i>	
PHYSICIAN'S NAME (Type) <i>Archibald G. Johnson</i>		22d. LOCATION (City, town or county) (State) <i>Hilltop Md</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>6-11-58</i>	22c. NAME OF CEMETERY OR CREMATORIAL <i>Zion Baptist</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Archibald G. Johnson</i>		ADDRESS <i>La Plata Md.</i>	24a. REC'D BY REGISTRAR DATE <i>JUN 13 '58</i>
VS A15 (4) 15M 10/57		24b. REGISTRAR'S SIGNATURE <i>Albert E. Johnson</i>	

